CLINICA LAS AMERICAS

Patient Information

Home Phone: _____ Cell Phone #: _____ Email Address_____

Patient Name: _____Social Security #:_____

Address: _____APT #_____

City: _____State: _____ Zip: _____

Sex ( ) M ( ) F Age: _____Birthdate: _____ ( ) Single ( ) Married ( ) Separated ( ) Divorced

Emergency Contact Name _____ Emergency Contact Number _____

Insurance Information

What type of insurance do you have ( ) Medicaid ( ) Medicare ( ) Private Insurance ( ) WC ( ) PI

Insurance company Name: _____ Policy Holder: _____

Policy #:_____Group #:_____Contract #:_____

Policy Holder Employer: _____ Policy Holder Social Sec. #:_____

Patient Employed by: _____Occupation: _____

Business address: _____Business Phone: _____

Additional Information

Race: White ( ) Hispanic ( ) Black or African American ( ) Asian ( ) Other ( ) Decline ( )
Ethnicity: Hispanic or Latino ( ) Non-Hispanic or Latino ( ) Decline ( )
Preferred Language: English ( ) Spanish ( ) Other ( )

Assignment of Benefits

I _____ the undersigned, have insurance coverage with (name of Ins, company) _____ and assign directly to Clinica Las Americas all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party

Name of Responsible Party (if minor): _____

Relation to Patient: _____Birthdate: _____ Soc. Sec #:_____

Address (if different from patients): _____Phone #:_____

City: _____State: _____Zip _____

Consent to Treat

I voluntarily authorize and consent to such medical care, treatment, and diagnostic test that Rene I Lopez Jr M.D. and his/her designated associates or assistants believe are necessary for me or my child.

Signature: _____Date: _____

CLINICA LAS AMERICAS

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Clinica Las Americas to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Clinica Las Americas describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Clinica Las Americas** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Bonnie Quinn at 8800 Long Point Road, Suite B., Houston, Texas 77055.

With this consent, Clinica Las Americas may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Clinica Las Americas may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Clinica Las Americas may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Clinica Las Americas restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Clinica Las Americas to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Clinica Las Americas may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable